NewYork-Presbyterian
The University Hospital of Columbia and Cornell

43530

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION/MEDICAL RECORDS

Patient Name (please print):	Maiden or Other Name (please print):	Patient Date of Birth: / /
Patient Address (please print)		
Telephone (Area Code and Number): ( )	Email address (please print):	Medical Record Number:

Name, address and telephone number of Person(s) or Entity to whom this Information will be sent. Please check If same as above ☐
Send to (please print):

RECORDS DEPOSITION SERVICE, INC.

Address (please print):

PO BOX 5054, SOUTHFIELD, MI 48086-5054

Telephone (Area Code and Number):

(248) 357-3330

Check the name of the Center to disclose information or choose Other Healthcare Provider (specify):
☐ NYP/Columbia University Medical Center (NYP/Allen Hospital; NYP/Morgan Stanley Children's Hospital) ☐ NYP/Weill Cornell Medical Center
☐ NYP/Westchester Division ☐ NYP/Lower Manhattan
☐ Other (Provide Name of Entity) _____
(please print)

Specify Information to be released (medical records will not be released unless a date of service(s) is identified on this form):

Medical Record from (insert date) _____ to (insert date) _____

☐ Hospital Admission ☐ Emergency Department ☐ Ambulatory Surgery ☐ Outpatient

Specify reports requested (i.e. Lab tests, Radiology Reports, Operative Reports, Discharge Summary, etc.):

PLEASE SEE THE ATTACHED SUBPOENA OR LETTER REQUEST

Include (Indicate by Initialing below): Please note that the information will not be released if not initialed.

_____ Alcohol/Drug Treatment _____ HIV/AIDS Related Information

_____ Mental Health Treatment (except psychotherapy notes) _____ Genetic Testing Information

Please consider the environment. When possible, NewYork-Presbyterian will provide the information you requested electronically please check preference:
☑ CD/DVD ☐ Electronic Delivery

Patients with an active myNYP.org account can request electronic delivery via secure web patient portal at no cost. Please confirm and initial below:
- I have an active myNYP.org account and understand the medical record(s) I requested will be sent to myNYP.org account;
- If my medical record(s) cannot be delivered to myNYP.org account it will be mailed to the above-stated address on CD/DVD

Patient or Personal Representative Initial _____

The purpose(s) for which disclosure is authorized (check where applicable): ☐ Individual's request Medical Care ☐ Insurance ☐ Immunization ☑ Legal
☐ Other (specify): _____
(please print)

I, or my authorized representative, request that health information regarding my care and treatment at NewYork-Presbyterian Hospital (NYP) be disclosed as describe on this form. I understand that:
- I may inspect and/or receive a copy of the information described on this Authorization by completing this form and signing below.
- Providers are permitted to charge reasonable fees to recover costs for inspections and/or copying.
- Treatment and payment will not be conditional on whether you sign this authorization. Signing is voluntary, however if you refuse to sign NYP will not release your records.
- By my specifically authorizing the release of HIV/AIDS related alcohol or drug treatment, or mental health treatment information that the recipient is prohibited fr re-disclosing such information without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rig at (212) 306-7450. These agencies are responsible for protecting my rights.
- Alcohol/drug treatment-related information or confidential HIV/AIDS related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.
- I may revoke this authorization at any time by providing written notice to NYP except to the extent that action has already been taken based on this authorization.
- I understand that this Authorization will expire on: Date _____ / _____ / _____ (provide date if less than 1 year) or 1 year after being signed.

_____ _____
Signature of Patient/personal representative (e.g., legal guardian) Date

_____
If personal representative, print name and relationship to patient

_____
Witness or Notary